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	185414	A. BUILDING _____ B. WING _____	C 04/04/2012

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MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

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F 000	INITIAL COMMENTS An abbreviated survey (KY18096) was initiated on 03/30/12 and completed on 04/04/12. The complaint was substantiated and deficiencies were cited at a scope and severity of "J" at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F323), and 42 CFR 483.75 Administration (F490), with Substandard Quality of Care at 42 CFR 483.25 Quality of Care. The facility failed to have an effective system to ensure adequate supervision and monitoring to prevent accidents for one of nine sampled residents (Resident #1). Resident #1 was assessed by the facility to have wandering behaviors and was at risk for elopement (leaving the facility without staff knowledge). The resident was admitted to the locked Unit of the facility, and staff was to monitor the resident's behaviors and provide diversion activities when the resident exhibited wandering behaviors. On 03/15/12 at 12:53 PM, the community, including the facility, experienced a power outage and the door alarm system in the locked Unit to the back door and the courtyard gate was deactivated and not supported by the facility's emergency generator power. On 03/15/12, Resident #1 exited the Unit's back door at 12:58 PM, went into the gated courtyard, and exited the courtyard gate at 1:01 PM. Two staff members were outside the facility at 1:04 PM, and observed Resident #1 walking in a grassy area behind the facility. The staff assisted Resident #1, unharmed, back inside the facility at 1:06 PM, eight minutes after the resident had exited the facility. The Immediate Jeopardy was determined to exist on 03/15/12 and continued until 03/29/12. The	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 000	Continued From page 1 facility completed corrective actions prior to the State Agency's investigation on 03/30/12; therefore, the Jeopardy was determined to be Past Jeopardy.	F 000		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observations, record review, and review of facility policies, it was determined the facility failed to have an effective system to ensure services were provided in accordance with each written comprehensive plan of care for one of nine sampled residents (Resident #1). The facility assessed Resident #1 as a risk for wandering behaviors and elopement (leaving the facility without staff's knowledge). The facility placed Resident #1 in the locked "Unit" and staff was to monitor and document the resident's behaviors and provide diversion activities when the resident exhibited wandering behaviors. On 03/15/12, a citywide power outage occurred between the hours of 12:43 PM and 4:04 PM. The alarms to the back door of the facility's locked Unit and the courtyard gate were deactivated. Review of the footage of the facility's video recording revealed Resident #1 exited through the back door at 12:58 PM without staff knowledge. During this time, staff on the locked Unit was caring for another resident and was not aware Resident #1 had exited the facility.	F 282	Past noncompliance: no plan of correction required.	

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Resident #1 exited the courtyard gate at 1:01 PM. The video surveillance revealed two staff members (Stock Control #1 and Assistant Activities Director) standing outside the facility at 1:04 PM, observed Resident #1 walking in the grassy area behind the facility, and ran to assist Resident #1 back inside the facility. Based on documentation on the incident and investigation reports and a review of video footage, facility staff assisted Resident #1 back inside the facility at 1:06 PM, eight minutes after the resident left the facility.

Interviews revealed facility staff was unaware the back door of the unit and the courtyard gate were not connected to the generator for emergency power during power outages.

The facility's failure to have an effective system in place to ensure services were provided in accordance with each individual's written plan of care was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was determined to exist on 03/15/12, and continued until 03/29/12. The facility completed corrective actions prior to the State Agency's investigation on 03/30/12; therefore, the Jeopardy was determined to be Past Jeopardy.

The findings include:

A review of the facility's Wander/Elopement Prevention Policy (revised on 01/23/12) revealed "Residents who are a threat to leave the facility unattended, due to confusion, without the knowledge of the facility staff" were to be identified in a wander/elopement book, assessed for elopement risk, and a plan of care was to be

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developed and implemented for those residents.

Review of the Missing Persons policy (revised 03/06/12) revealed all residents should receive adequate supervision to prevent elopement.

A review of an incident and investigation report dated 03/15/12 revealed a citywide power outage occurred between the hours of 12:43 PM and 4:04 PM. The report revealed the Unit door and the courtyard gate were not connected to the emergency generator power and were without alarms during the power outage. Based on the report, Resident #1 exited the facility unnoticed by the staff. Documentation in the report revealed staff assigned to work the Unit on 03/05/12, Certified Nurse Aide (CNA) #1, CNA #2, and Licensed Practical Nurse (LPN) #1, was in another resident's room and was not aware Resident #1 had left the facility. A review of the facility's video footage revealed Resident #1 exited the courtyard gate at 1:01 PM, two staff members (Stock Control #1 and Assistant Activities Director) were standing outside the facility at 1:04 PM, and observed Resident #1 walking in the grassy area behind the facility and assisted Resident #1 back into the facility. A residential area was noted to be approximately 20 feet away from the grassy area where the resident was located. Based on documentation on the incident/investigation reports and a review of video footage, facility staff assisted Resident #1 back inside the facility at 1:06 PM, eight minutes after the resident left the facility

A review of Resident #1's medical record revealed the facility admitted the resident on 03/08/12 with a Diagnosis of Alzheimer's Disease

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and Severe Impairment. Resident #1 was a known risk for elopement from home and was assigned to the locked Unit. A comprehensive care plan developed on 03/08/12 revealed the facility would monitor Resident #1's wandering behaviors. The care plan was revised on 03/12/12 to include Resident #1's behaviors of wandering toward exit doors, trying to get out of the exit doors, and stating he/she was going home. Facility staff noted the resident was at risk for getting to a potentially unsafe area or out of the facility. Interventions on the revised care plan revealed staff was to monitor the resident's behaviors, alert staff when the resident exhibited wandering behavior, provide diversion activities, approach the resident in a calm manner at all times, and redirect the resident "as needed." The care plan indicated if Resident #1 wandered away from the Unit, staff was to stay with the resident, converse, and gently persuade the resident to walk back to the designated areas with them. In addition, the plan revealed staff was to follow the elopement protocol, remind visitors to inform staff when leaving the designated area with the resident, and that Social Services was to evaluate the resident on an "as needed" basis.

A comprehensive admission assessment dated 03/14/12 revealed Resident #1's wandering behaviors occurred daily.

Interview with the Minimum Data Set (MDS) Coordinator on 04/03/12, at 1:45 PM, revealed she developed care plans based on each resident's diagnosis and conditions. According to the MDS Coordinator, Resident #1 had a diagnosis of Dementia, required a locked unit, and staff was aware to monitor Resident #1

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closely. In addition, the MDS Coordinator stated Resident #1 was identified to be at risk for wandering /elopement. Interventions were developed that included alerting staff of the resident's wandering behaviors, offering the resident activities as a diversion, calling the resident's family members to come to the facility to sit with the resident, and to follow established protocols if the resident left the facility without staff knowledge.

A review of the nursing notes dated 03/15/12, at 1:00 PM, in Resident #1's medical record revealed LPN #1, CNA #1, and CNA #2 were in a resident's room located in the Unit, and Resident #1 exited the facility and courtyard without the staff's knowledge. Based on documentation in the nursing notes, Resident #1 was returned to the facility by staff, was assessed to have no injuries, was in no distress, and would be monitored.

Interviews conducted with CNAs #1, #2, #3, #4, and #5 on 04/02/12, at 9:05 AM, 9:30 AM, 10:25 AM, 11:30 AM, and 12:25 PM; with LPNs #1, #2, #3, and #4 on 04/03/12, at 2:45 PM, 2:55 PM, 3:00 PM, and 3:10 PM; and with the Maintenance Director on 04/02/12, at 2:30 PM, revealed they were aware Resident #1 had been assessed to exhibit wandering/elopement behaviors and were knowledgeable of interventions to implement in the event a resident eloped from the facility. LPNs #1, #2, #3, and #4 stated they checked the Unit's doors every two hours on their shift to ensure the doors were functioning properly and had not identified any problems. The nurses stated any identified concerns with the door alarms would be

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immediately reported to Maintenance and Administration. However, staff revealed they did not know the back door of the Unit and courtyard gate to the Unit were not on emergency generator power. The nurses also stated care plans were developed by the nurses and the Minimum Data Set (MDS) Coordinators and were updated when there were changes in a resident's condition. In addition, staff interviews revealed CNA care plans were developed and/or updated by nurses and carried by all CNAs. The CNA care plans included information related to care provided for each resident.
Interview with the Administrator, Assistant Administrator, and the Director of Nursing on 03/30/12, at 10:35 AM, revealed the administrative staff knew Resident #1 was an elopement risk, was assigned a room in the locked Unit, and was to be monitored closely, per the plan of care. The administrative staff was unaware the back door of the Unit or the gate to the courtyard was not on emergency generator power, leaving the doors unlocked and without alarms during a power outage.

Interview with Resident #1 was attempted on 03/30/12, at 10:30 AM. However, due to the resident's severely impaired cognition he/she had no memory of the elopement. Observations of Resident #1 on 03/30/12, at 10:30 AM and 11:30 AM, and on 04/02/12, at 9:30 AM, 10:20 AM, and 11:30 AM, revealed staff provided one to one supervision of the resident and escorted the resident throughout the facility to activities, therapies, and the dining room for meals.

*The facility implemented the following actions to correct the deficiency:

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-Resident #1's family member was notified of the incident on 03/15/12, at 1:10 PM, and the family member came to the facility to sit with Resident #1 until the power was restored.

-Resident #1 was placed on one to one supervision on 03/15/12 and remains on one to one supervision.

-Resident #1's physician was notified at 1:30 PM on 03/15/12 of the incident and no new orders were received by the facility.

-The Medical Director was notified of the incident on 03/15/12.

-Resident #1's care plan was reviewed on 03/15/12 and updated to include one to one supervision of Resident #1.

-The care plans of the other ambulatory residents in the Unit that were also identified as an elopement risk were reviewed on 03/15/12 and revised as needed to ensure resident safety.

-An investigation was initiated immediately by the Assistant Administrator (AADM), Director of Nursing (DON), and Maintenance Director to determine how Resident #1 exited the building on 03/15/12.

-The AADM continuously monitored the Unit's back door and the courtyard gate from 03/15/12, at 1:06 PM, until the power was restored on 03/15/12, at 4:04 PM.

-An in-service regarding what to do in the event of

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a power outage in the Unit was held on 03/15/12 with all staff working on the unit. The in-service included close monitoring of elopement risk residents per the plan of care.

-A sign was posted on the medication room door in the Unit on 03/15/12 to inform staff that "if the electricity goes out, the doors will unlock and the residents should be monitored closely."

-The AADM contacted the local power company to report the power outage on 03/15/12, at 1:15 PM.

-The Maintenance Director contacted the electric company on 03/15/12 to evaluate the door/gate in the Unit in order to have them placed on emergency generator power.

-All exit doors and stairwell doors in the building were checked on 03/15/12, at 1:30 PM, and found to be locked, armed, and functioning properly on generator power, except the back door to the Unit and the courtyard gate.

-An in-service regarding the Unit door/courtyard gate and power outages was completed on 03/28/12 and 03/29/12 for other licensed nursing staff and CNAs that did not work in the Unit but may be "pulled" into the Unit to work

-A "check sheet" was implemented on 03/28/12 to document the Unit door alarms were monitored every two hours.

-As part of the facility's Continuous Quality Improvement (CQI), the door alarm checks will be monitored during shift change and the Unit doors

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will be monitored every two hours by the nursing staff and the results of the monitoring will be reported quarterly at the CQI meetings. The CQI committee met on 03/15/12 and 03/28/12 to review care plans and policies.

-The back door of the Unit and the courtyard gate were connected to the emergency generator power on 03/30/12 to ensure locks/alarms were functional in the event of an electrical power outage. This was scheduled on 03/15/12 by the Maintenance Director.

**The surveyor validated the corrective action taken by the facility as follows:

-Interview with the Administrator, Assistant Administrator (AADM), and Director of Nursing (DON) on 03/30/12, at 10:25 AM, revealed the Assistant Administrator monitored the Unit's back door and courtyard gate from 03/15/12, at 1:06 PM, until power was restored on 03/15/12, at 4:04 PM, to the facility. Interview with LPN #1 on 04/02/12, at 11:35 AM, confirmed the fact that the AADM monitored the Unit door until the power was restored on 03/15/12, at 4:04 PM.

-Review of Resident #1's care plan confirmed revisions were made to the care plan following the incident on 03/15/12.

-Observations of Resident #1 on 03/30/12, at 10:30 AM and 11:30 AM, and on 04/02/12, at 9:30 AM, 10:20 AM, and 11:30 AM, revealed staff provided one to one supervision of the resident and escorted the resident throughout the facility to activities, therapies, and the dining room for meals.

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F 282	Continued From page 10 -Interview with the AADM on 04/03/12, at 4:00 PM, and a review of documentation in resident care plans and the "wandering/elopement" book revised on 03/15/12 revealed all elopement risk care plans were reviewed and checked for accuracy (Residents #1, #2, #4, #5, #6, #7, #8, and #9). No discrepancies were found with the elopement care plans. According to the AADM, the "wandering/elopement" book was reviewed for all residents assessed to be at risk for elopement/wandering behaviors, with updated pictures, personal identification, and room numbers. -A review of in-service provided for staff working the Unit on 03/15/12 revealed staff was to closely monitor residents assessed by the facility to be at risk for wandering/elopement and were to monitor the back door of the Unit and the courtyard gate in the event of a power outage because the doors would not lock and/or alarm. In-services continued on 03/28/12 and 03/29/12 for staff that did not routinely work the Unit but could potentially be assigned to work in the Unit. Interviews with CNAs #1, #2, #3,#4, #5, #6, #7,#8, and #9, and LPNs #1, #2, #3, and #4 on 04/02/12, at 9:05 AM, 9:30 AM, 10:25 AM, 11:30 AM, 12:25 PM, 1:30 PM, and 2:00 PM, and on 04/03/12, at 2:15 PM, 2:25 PM, 2:45 PM, 2:55 PM, 3:00 PM, and 3:10 PM respectively, revealed staff had been in-serviced and informed the back door of the Unit and the courtyard gate would not lock or alarm in the event of a power outage and should be monitored if a power outage occurred. In addition, staff interviewed acknowledged residents at risk for elopement were to be closely monitored at all times, including when a power	F 282		

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F 282	Continued From page 11 outage occurred. -Review of the CQI minutes and interview with the Administrator on 04/04/12, at 11:00 AM, revealed meetings had been held with the Administrative staff (Administrator, Assistant Administrator, Director of Nursing, Minimum Data Set (MDS) Coordinator, and Social Services Director) on 03/15/12, 03/16/12, and 03/28/12 to review care plans for Resident #1 and other residents assessed to be at risk for wander/elopement behaviors and to ensure care plans were implemented. The Administrator also stated the Administrative staff/CQI committee reviewed, revised, and created policies, reviewed in-service content and training, and developed forms for staff to document that the Unit door and the courtyard gate locks/alarms were monitored and functioning. -Reviews of the Door Alarm Policy (reviewed by the facility on 03/15/12), Missing Persons Policy (revised by the facility on 03/15/12), and Wander/Elopement Prevention Policy (reviewed by the facility on 03/15/12) were conducted with no concerns identified.	F 282		
F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation and the facility's policy, it was determined the facility failed to have an effective system to ensure adequate supervision and monitoring to prevent accidents for one of nine sampled residents (Resident #1). The facility assessed and identified Resident #1 and eight other residents to be at risk for wandering and elopement (leaving the facility without staff knowledge) behaviors. Resident #1 was in the locked Unit of the facility and staff was to monitor and document resident behaviors. On 03/15/12 at 12:53 PM, the community, including the facility, experienced a power outage and the door alarm system in the locked Unit to the back door and the courtyard gate was deactivated and not supported by the facility's emergency generator power. On 03/15/12, Resident #1 exited the Unit's back door at 12:58 PM, went into the gated courtyard, and exited the courtyard gate at 1:01 PM. Two staff members were outside the facility at 1:04 PM, and observed Resident #1 walking in a grassy area behind the facility. The staff assisted Resident #1, unharmed, back inside the facility at 1:06 PM, eight minutes after the resident had exited the facility. Interview revealed staff was in another resident's room during Resident #1's elopement and was unaware the resident had exited the building until facility staff returned Resident #1 to the Unit at 1:06 PM. Staff was unaware the back door of the Unit and the courtyard gate were not connected to the facility's emergency generator power in the	F 323	Past noncompliance: no plan of correction required.	

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event of a power outage.

The facility's failure to have an effective system in place to ensure adequate supervision and monitoring for residents who were at risk for wandering/elopement behaviors was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was determined to exist on 03/15/12, and continued until 03/29/12. The facility completed corrective actions prior to the State Agency's investigation on 03/30/12; therefore, the Jeopardy was determined to be Past Jeopardy.

The findings include:

Review of the facility's Wander/Elopement Prevention Policy (revised on 01/23/12) revealed "Residents who are a threat to leave the facility unattended, due to confusion, without the knowledge of the facility staff" would be identified in a wander/elopement book, assessed for risk of elopement, and a plan of care would be developed and implemented. The purpose of the policy was to ensure the resident's safety utilizing the least restrictive means available. The policy further revealed staff was to pay close attention to the whereabouts of the residents, call a "Code Green" for residents attempting to leave the facility, and to intervene as necessary.

The "Code Green" policy (undated) revealed residents at risk for elopement were monitored. According to the policy, if a resident attempted to leave the facility, the nurse would call the "Code Green" over the intercom system and announce the resident's room and bed number to alert staff to the risk of elopement by that resident. The

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policy also revealed staff would conduct observations of the resident every 15 minutes until the staff determined the resident was no longer an immediate risk for elopement.

Review of the Door Alarm Policy dated 04/06/09 revealed nurses were to make walking rounds at shift change to assure all the exit doors and stairwells were armed and locked. If a door was not locked and armed, the door was to be locked and armed immediately and Maintenance and Administration were to be informed.

Review of the Missing Persons policy (revised 03/06/12) revealed all residents should receive adequate supervision to prevent elopement.

Review of the facility's "wandering/elopement" book revealed the facility had assessed a total of nine residents, including Resident #1, as being at risk for wandering and/or elopement. A book was located in each department of the facility and at each nursing station. Each book included pictures of the residents, identifying information of the residents, and room numbers for each of the nine residents in the book.

An incident and investigation report dated 03/15/12 revealed the facility experienced a power outage between the hours of 12:53 PM and 4:04 PM, and the facility's emergency generated power was activated. A review of the report revealed the Unit door and the courtyard gate were not on the emergency power, were unlocked, and were without alarms during the power outage. According to the report and a review of video surveillance, Resident #1 exited through the back door of the Unit on 03/15/12, at

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12:58 PM, went into the courtyard, and exited through the courtyard gate at 1:01 PM. The report revealed the three staff members assigned to the unit were in another resident's room at the time Resident #1 exited the facility unsupervised by staff. Continued review of the report and video surveillance revealed two staff members (Stock Control #1 and the Assistant Activities Director) were outside the facility at 1:04 PM, observed Resident #1 walking in a grassy area behind the facility, and assisted Resident #1 back into the facility at 1:06 PM (eight minutes after the resident exited the locked Unit). A review of the video surveillance revealed a residential area with four homes was located approximately twenty feet away from the grassy area behind the facility.

Review of Resident #1's medical record revealed the facility admitted the resident on 03/08/12 with a diagnosis of Alzheimer's Disease. Staff assessed the resident's cognition was severely impaired. In addition, the facility noted Resident #1 had a history of elopement from his/her home. A comprehensive care plan developed on 03/08/12 revealed the facility would monitor the resident's behaviors. A revised care plan was implemented on 03/12/12 related to the resident's risk of elopement as evidenced by the resident wandering toward exit doors, trying to get out of the exit doors, and stating he/she was going home. Staff also assessed Resident #1 to be at risk for getting to a potentially unsafe area or out of the facility. Interventions related to the resident's care plan included monitoring/alerting staff of the resident's wandering behaviors, provide the resident with diversion activities, approach the resident in a calm manner at all times, and redirect the resident as needed. If

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Resident #1 was observed wandering away from the Unit, staff was to stay with the resident, converse, and gently persuade the resident to walk back to designated areas with them, follow the elopement protocol, and to remind visitors to inform staff when they were leaving the designated area with the resident. In addition, Social Services was to evaluate Resident #1 as needed.

The Social Services Director (SSD) stated in interview conducted on 04/03/12, at 2:50 PM, that elopement risk assessments were completed quarterly, annually, and as needed by the SSD. According to the SSD, she had developed a behavior management care plan for Resident #1 related to his/her wandering behaviors and had also completed an elopement assessment for the resident on 03/14/12.

A comprehensive admission assessment dated 03/14/12 revealed Resident #1's wandering behaviors occurred daily.

Based on documentation in the nurse's notes of Resident #1's medical record dated 03/15/12, at 1:00 PM, Licensed Practical Nurse (LPN) #1, Certified Nurse Aide (CNA) #1, and CNA #2 were in a resident's room at the time Resident #1 exited the facility and courtyard. Continued review of the notes revealed at 1:06 PM on 03/15/12, after the incident, Resident #1 was assessed to have no injuries, was in no distress, and was to be monitored.

Interview with LPN #1 on 04/02/12, at 11:35 AM, revealed the nurse was called to a resident's room by two CNAs to assist with the resident's

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care "sometime close to 1:00 PM" on 03/15/12. LPN #1 stated Resident #1 must have exited during that time because at 1:06 PM, two staff members returned Resident #1 to the nurses' station and reported he had been outside of the facility. According to the LPN, Resident #1 was immediately placed on "one to one" supervision, and the Administrator was contacted. LPN #1 said the Assistant Administrator came and monitored the back exit door while the power remained off until 4:04 PM and Resident #1's family and primary care physician were notified of the incident. LPN #1 said Resident #1 sustained no injuries as the result of exiting the facility.

Interview with CNAs #1 and #2 on 04/02/12, at 9:05 AM and 9:30 AM, revealed the CNAs were in another resident's room when Resident #1 exited the facility unattended. The CNAs did not know the exit door to the Unit or the courtyard doors were unlocked and without alarms when the electric power was not available. The CNAs stated Resident #1 had a risk for wandering/elopement and if they had known the door alarms were not functioning, they would not have left Resident #1 without staff.

Interviews conducted with CNAs #1, #2, #3, #4, and #5 on 04/02/12, at 9:05 AM, 9:30 AM, 10:25 AM, 11:30 AM, and 12:25 PM; and with LPNs #1, #2, #3, and #4 on 04/03/12, at 2:45 PM, 2:55 PM, 3:00 PM, and 3:10 PM, revealed they were aware Resident #1 had been assessed to wander and that he/she was in the book of residents that exhibited behaviors of wandering/elopement located at each nursing unit. The interviews with the staff also revealed they knew what to do in the event of an elopement. Interviews revealed

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the staff did not know the back door of the Unit and courtyard gate to the Unit were not on emergency generator power. LPNs #1, #2, #3, and #4 stated they checked the Units doors during walking rounds every two hours on every shift, had not identified any concerns, and would have immediately reported any concerns to the Maintenance Department and Administration. The staff interviewed stated they knew Resident #1 had behaviors of going to the exit doors and pushing the doors which caused the alarm to sound. Staff also stated in the event Resident #1 exhibited behaviors, staff was to assist the resident to perform tasks that distracted him/her from the exit seeking behaviors.

An interview with the Maintenance Director on 04/02/12, at 2:30 PM, revealed he was unaware the exit door to the Unit and the courtyard gate were not on emergency generator power. According to the Maintenance Director, the generator was on a timer and was activated on a weekly basis for a "performance" test. The Maintenance Director stated the door/lock system had remained on and locked when tested. The Maintenance Director also stated the keypad codes on doors were changed as needed, and that nurses checked the doors and alarms routinely to ensure they worked properly. In addition, according to the Maintenance Director, all doors in the building were checked on 03/15/12 after Resident #1 exited the building unsupervised to ensure they were working properly and stated all other doors were in working condition and on generator power. The Maintenance Director contacted the power company on 03/15/12 to get the Unit door and gate on emergency generator power, however,

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the electric company could not make the needed repairs until 03/30/12.

Interview with the facility's local power company on 04/04/12, at 10:00 AM, revealed the facility had contacted the company on 03/15/12 regarding the need for the exit door to the Unit and the courtyard door to be placed on emergency generator power. The company stated they were not located in the same community as the facility and, because of recent tornado damage, the company had been "swamped" and had been unable to assess and/or connect the facility's door/gate to generated power before 03/30/12.

The Administrator, Assistant Administrator, and the Director of Nursing (DON) stated in interview on 04/02/12, at 3:00 PM, that they were unaware the back door to the Unit and the courtyard gate did not lock and/or alarm in the event of electrical power failure. The Administrative staff stated all of the other doors in the facility ran on emergency generator power and they thought the door to the Unit and the courtyard gate did the same. Interview revealed generator power was added to the Unit door/gate on 03/30/12 by an electrician. The Administrator stated the electrician was contacted immediately by the Maintenance Director after Resident #1 left the facility unsupervised and confirmed the electric company was unable to perform the needed service until 03/30/12. In addition, the Administrative staff conducted in-service training for staff on 03/15/12 related to when the electricity was off, the exit door of the unit and the courtyard gate were unarmed and unlocked, and staff was to monitor the doors and residents closely. Interview

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revealed a sign was posted by the DON on the Unit to inform staff/residents/visitors that the back door of the Unit and the courtyard gate were unlocked and unarmed in the event of a power outage to ensure the residents were monitored and safe.

Observations of Resident #1 on 03/30/12, at 10:30 AM and 11:30 AM, and on 04/02/12, at 9:30 AM, 10:20 AM, and 11:30 AM revealed staff provided one to one supervision of the resident and escorted the resident throughout the facility to activities, therapies, and the dining room for meals. An interview with Resident #1 was attempted on 03/30/12, at 10:30 AM, but due to the resident's severely impaired cognition, was unsuccessful.

*The facility implemented the following actions to correct the deficiency:

-An investigation was initiated immediately by the Assistant Administrator (AADM), Director of Nursing (DON), and Maintenance Director to determine how Resident #1 exited the building on 03/15/12.

-The AADM continuously monitored the Unit's back door and the courtyard gate from 03/15/12, at 1:06 PM, until the power was restored on 03/15/12, at 4:04 PM.

-Resident #1's family member was notified of the incident on 03/15/12, at 1:10 PM, and the family member came to the facility to sit with Resident #1 until the power was restored.

-Resident #1 was placed on one to one

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supervision on 03/15/12 and remains on one to one supervision.

-Resident #1's physician was notified at 1:30 PM on 03/15/12 of the incident and no new orders were received by the facility.

-The Medical Director was notified of the incident on 03/15/12.

-Resident #1's care plan was reviewed on 03/15/12 and updated.

-An in-service regarding what to do in the event of a power outage in the Unit was held on 03/15/12 with all staff working the unit.

-A sign was posted on the medication room door in the Unit on 03/15/12 to inform staff that "if the electricity goes out, the doors will unlock and the residents should be monitored closely."

-The AADM contacted the local power company to report the power outage on 03/15/12, at 1:15 PM.

-The Maintenance Director contacted the electric company on 03/15/12 to evaluate the door/gate in the Unit in order to have them placed on emergency power generator.

-All exit doors and stairwell doors in the building were checked on 03/15/12, at 1:30 PM, and found to be locked, armed, and functioning properly on generator power, except the back door to the Unit and the courtyard gate.

-The care plans of the other ambulatory residents

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in the Unit that were also identified as an elopement risk were reviewed on 03/15/12 and revised as needed to ensure resident safety.

-An in-service regarding the Unit door/courtyard gate and power outages was completed on 03/28/12 and 03/29/12 for other licensed nursing staff and CNAs that did not work in the Unit but may be "pulled" into the Unit to work

-A "check sheet" was implemented on 03/28/12 to document the Unit door alarms were monitored every two hours.

-As part of the facility's Continuous Quality Improvement (CQI), the door alarm checks will be monitored during shift change and the Unit doors will be monitored every two hours by the nursing staff and the results of the monitoring will be reported quarterly at the CQI meetings. The CQI committee met on 03/15/12 and 03/28/12 to review care plans and policies.

-The back door of the Unit and the courtyard gate were connected to the emergency generator power on 03/30/12 to ensure locks/alarms were functional in the event of an electrical power outage. This had been scheduled on 03/15/12 by the Maintenance Director.

**The surveyor validated the corrective action taken by the facility as follows:

-Interview with the Administrator, Assistant Administrator (AADM), and Director of Nursing (DON) on 03/30/12, at 10:25 AM, revealed the Assistant Administrator monitored the Unit's back door and courtyard gate from 03/15/12, at 1:06

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PM, until power was restored on 03/15/12, at 4:04 PM, to the facility. Interview with LPN #1 on 04/02/12, at 11:35 AM, confirmed the AADM monitored the Unit door until the power was restored on 03/15/12, at 4:04 PM.

-Review of Resident #1's care plan confirmed revisions were made to the care plan following the incident on 03/15/12.

-Observations of Resident #1 on 03/30/12, at 10:30 AM and 11:30 AM, and on 04/02/12, at 9:30 AM, 10:20 AM, and 11:30 AM, revealed staff provided one to one supervision of the resident and escorted the resident throughout the facility to activities, therapies, and the dining room for meals.

-Interview with the AADM on 04/03/12, at 4:00 PM, and a review of documentation in resident care plans and the "wandering/elopement" book revised on 03/15/12 revealed all elopement risk care plans were reviewed and checked for accuracy (Residents #1, #2, #4, #5, #6, #7, #8, and #9). No discrepancies were found with the elopement care plans. According to the AADM, the "wandering/elopement" book was reviewed for all residents assessed to be at risk for elopement/wandering behaviors, with updated pictures, personal identification, and room numbers.

-A review of in-service provided for staff working the Unit on 03/15/12 revealed staff was to closely monitor residents assessed by the facility to be at risk for wandering/elopement and was to monitor the back door of the Unit and the courtyard gate in the event of a power outage because the doors

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would not lock and/or alarm. In-services continued on 03/28/12 and 03/29/12 for staff that did not routinely work the Unit but could potentially be assigned to work in the Unit. Interviews conducted with CNAs #1, #2, #3, #4, and #5 on 04/02/12, at 9:05 AM, 9:30 AM, 10:25 AM, 11:30 AM, and 12:25 PM; and with LPNs #1, #2, #3, and #4 on 04/03/12, at 2:45 PM, 2:55 PM, 3:00 PM, and 3:10 PM, revealed staff had been in-serviced and informed the back door of the Unit and the courtyard gate would not lock or alarm in the event of a power outage and should be monitored if a power outage occurred. In addition, staff interviewed acknowledged residents at risk for elopement were to be closely monitored at all times, including when a power outage occurred.

-Review of the CQI minutes and interview with the Administrator on 04/04/12, at 11:00 AM, revealed meetings had been held with the Administrative staff (Administrator, Assistant Administrator, Director of Nursing, Minimum Data Set (MDS) Coordinator, and Social Services Director) on 03/15/12, 03/16/12, and 03/28/12 to update care plans for Resident #1 and other residents assessed to be at risk for wander/elopement behaviors. The Administrator also stated the administrative staff/CQI committee reviewed, revised, and created policies; reviewed in-service content and training; and developed forms for staff to document the Unit door and the courtyard gate locks/alarms were monitored and functioning.

-Reviews of the Door Alarm Policy (reviewed by the facility on 03/15/12) Missing Persons Policy (revised by the facility on 03/15/12), and

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MOUNTAIN MANOR OF PAINTSVILLE	1025 EUCLID AVENUE PAINTSVILLE, KY 41240

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F 323	Continued From page 25 Wander/Elopement Prevention Policy (reviewed by the facility on 03/15/12) were conducted with no concerns identified. -Interview with the facility's local power company on 04/04/12, at 10:00 AM, confirmed the facility had contacted the company on 03/15/12 regarding the need for the exit door to the Unit and the courtyard door to be placed on emergency generator power.	F 323		
F 490	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and a review of the facility's investigation, it was determined the facility's Administration failed to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one of nine sampled residents (Resident #1). The facility failed to have an effective system to ensure policy and procedures were implemented related to supervision to prevent accidents for residents who were identified at risk for elopement/wandering in the facility's locked Unit.	F 490	Past noncompliance: no plan of correction required.	

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The facility Administration failed to have an effective system to ensure the magnetic door lock and alarm systems for the locked Unit were effective in protecting residents who were assessed to be at risk for elopement (leaving the facility without staff knowledge). The facility also failed to have an effective system in place to ensure the Comprehensive Plan of Care was implemented to ensure supervision and monitoring of Resident #1 to prevent elopement. (Refer to F282 and F323.)

On 03/15/12 at 12:53 PM, the community, including the facility, experienced a power outage and the door alarm system in the locked Unit to the back door and the courtyard gate was deactivated and not supported by the facility's emergency generator power. At 12:58 PM, Resident #1, assessed by the facility to be at risk for elopement (leaving the facility without staff knowledge), exited the back door of the Unit, traveled through the courtyard, and exited the gate without staff knowledge. The resident was found on the grassy area behind the facility within twenty feet of a residential street and four houses.

This failure has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. Immediate Jeopardy was determined to exist on 03/15/12, and continue until 03/29/12. The facility implemented corrective actions which were completed prior to the State Agency's investigation on 03/30/12, therefore, the Jeopardy was determined to be Past Jeopardy.

The findings include:

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F 490	Continued From page 27 A review of the facility's Wander/Elopement Prevention Policy (revised on 01/23/12) revealed "Residents who are a threat to leave the facility unattended, due to confusion, without the knowledge of the facility staff" were to be identified in a wander/elopement book, assessed for elopement risk, and a plan of care was to be developed and implemented for those residents. Review of the Missing Persons policy (revised 03/06/12) revealed all residents should receive adequate supervision to prevent elopement. An incident and investigation report dated 03/15/12 revealed a citywide power outage occurred between the hours of 12:53 PM and 4:04 PM. Based on the report, the Unit door and courtyard were without alarms during the power outage and Resident #1 exited the facility unnoticed by the staff. The report revealed staff assigned to work the Unit on 03/05/12, Licensed Practical Nurse (LPN) #1, Certified Nurse Aide (CNA) #1, and CNA #2, was in another resident's room and was not aware Resident #1 had left the facility. A review of the facility's video footage revealed Resident #1 exited the courtyard gate at 1:01 PM, and at 1:04 PM, Stock Control #1 and the Assistant Activities Director observed Resident #1 walking in the grassy area behind the facility and assisted Resident #1 back inside the facility at 1:06 PM, eight minutes after the resident left the facility. Interview with LPN #1 on 04/02/12 at 11:35 AM revealed the nurse was called to a resident's room by two (2) CNAs to assist with the resident's care and Resident #1 must have exited during	F 490		

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that time.

Interview with CNA #1 and #2 on 04/02/12 at 9:05 AM and 9:30 AM revealed the CNAs were in another resident's room when Resident #1 exited the facility unattended. The CNAs did not know the exit door to the Unit or the court yard doors were unlocked and without alarms when the electric power was not available. The CNAs stated if they had known the door alarms were not functioning, they would not have left the Resident #1 without staff.

Interviews conducted with LPNs #1, #2, #3, and #4 on 04/03/12, at 2:45 PM, 2:55 PM, 3:00 PM, and 3:10 PM revealed they checked the Unit's doors every two hours during their shift to ensure the doors were functioning properly and would have reported any identified concerns to Maintenance and Administration. Staff stated they did not know the back door of the Unit and courtyard gate were not connected to the emergency generator.

An interview with the Maintenance Director on 04/02/12 at 2:30 PM revealed he was unaware the exit door to the Unit and the courtyard gate were not on emergency generator power. The Maintenance Director contacted the power company on 03/15/12 to get the Unit door and gate on emergency generator power, however the electric company could not make the needed repairs until 03/30/12.

The Administrator, Assistant Administrator, and the Director of Nursing (DON) stated in interview conducted on 03/30/12, at 10:35 AM, that they were unaware the door from the Unit and the

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courtyard gate were not connected to the emergency generator power source and were unlocked and without alarms during a power outage. In addition, the Administrator, the Assistant Administrator, and the DON acknowledged facility staff had failed to follow Resident #1's plan of care, had left Resident #1 unsupervised and, as a result, were unaware the resident left the building.

*The facility implemented the following actions to correct the deficiency:

-An investigation was initiated immediately by the Assistant Administrator (AADM), Director of Nursing (DON), and Maintenance Director to determine how Resident #1 exited the building on 03/15/12.

-The AADM continuously monitored the Unit's back door and the courtyard gate from 03/15/12, at 1:06 PM until the power was restored on 03/15/12, at 4:04 PM.

-Resident #1's family member was notified of the incident on 03/15/12, at 1:10 PM, and the family member came to the facility to sit with Resident #1 until the power was restored.

-Resident #1 was placed on one to one supervision on 03/15/12 and remains on one to one supervision.

-Resident #1's physician was notified at 1:30 PM on 03/15/12 of the incident and no new orders were received by the facility.

-The Medical Director was notified of the incident

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on 03/15/12.

-Resident #1's care plan was reviewed on 03/15/12 and updated.

-An in-service regarding what to do in the event of a power outage in the Unit was held on 03/15/12 with all staff working the unit.

-A sign was posted on the medication room door in the Unit on 03/15/12 to inform staff that "if the electricity goes out, the doors will unlock and the residents should be monitored closely."

-The AADM contacted the local power company to report the power outage on 03/15/12, at 1:15 PM.

-The Maintenance Director contacted the electric company on 03/15/12 to evaluate the door/gate in the Unit in order to have them placed on emergency power generator.

-All exit doors and stairwell doors in the building were checked on 03/15/12, at 1:30 PM, and found to be locked, armed, and functioning properly on generator power, except the back door to the Unit and the courtyard gate.

-The care plans of the other ambulatory residents in the Unit that were also identified as an elopement risk were reviewed on 03/15/12 and revised as needed to ensure resident safety.

-An in-service regarding the Unit door/courtyard gate and power outages was completed on 03/28/12 and 03/29/12 for other licensed nursing staff and CNAs that did not work in the Unit but

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may be "pulled" into the Unit to work

-A "check sheet" was implemented on 03/28/12 to document the Unit door alarms were monitored every two hours.

-As part of the facility's Continuous Quality Improvement (CQI), the door alarm checks will be monitored during shift change and the Unit doors will be monitored every two hours by the nursing staff and the results of the monitoring will be reported quarterly at the CQI meetings. The CQI committee met on 03/15/12 and 03/28/12 to review care plans and policies.

-The back door of the Unit and the courtyard gate were connected to emergency generator power on 03/30/12 to ensure locks/alarms were functional in the event of an electrical power outage. This was scheduled on 03/15/12 by the Maintenance Director.

**The surveyor validated the corrective action taken by the facility as follows:

-Interview with the Administrator, Assistant Administrator (AADM), and Director of Nursing (DON) on 03/30/12, at 10:25 AM, revealed the Assistant Administrator monitored the Unit's back door and courtyard gate from 03/15/12, at 1:06 PM, until power was restored on 03/15/12, at 4:04 PM, to the facility. Interview with LPN #1 on 04/02/12, at 11:35 AM, confirmed the fact that the AADM monitored the Unit door until the power was restored on 03/15/12, at 4:04 PM.

-Review of Resident #1's care plan confirmed revisions were made to the care plan following

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the incident on 03/15/12.

-Observations of Resident #1 on 03/30/12, at 10:30 AM and 11:30 AM, and on 04/02/12, at 9:30 AM, 10:20 AM, and 11:30 AM, revealed staff provided one to one supervision of the resident and escorted the resident throughout the facility to activities, therapies, and the dining room for meals.

-Interview with the AADM on 04/03/12, at 4:00 PM, and a review of documentation in resident care plans and the "wandering/elopement" book revised on 03/15/12 revealed all elopement risk care plans were reviewed and checked for accuracy (Residents #1, #2, #4, #5, #6, #7, #8, and #9). No discrepancies were found with the elopement care plans. According to the AADM, the "wandering/elopement" book was reviewed for all residents assessed to be at risk for elopement/wandering behaviors, with updated pictures, personal identification, and room numbers.

-A review of in-service provided for staff working the Unit on 03/15/12 revealed staff was to closely monitor residents assessed by the facility to be at risk for wandering/elopement and were to monitor the back door of the Unit and the courtyard gate in the event of a power outage because the doors would not lock and/or alarm. In-services continued on 03/28/12 and 03/29/12 for staff that did not routinely work the Unit but could potentially be assigned to work in the Unit. Interviews with CNAs #1, #2, #3,#4, #5, #6, #7,#8, and #9, LPNs #1, #2, #3, and #4 on 04/02/12, at 9:05 AM, 9:30 AM, 10:25 AM, 11:30 AM, 12:25 PM, 1:30 PM, and 2:00 PM, and on

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F 490	Continued From page 33 04/03/12, at 2:15 PM, 2:25 PM, 2:45 PM, 2:55 PM, 3:00 PM, and 3:10 PM, revealed staff had been in-serviced and informed the back door of the Unit and the courtyard gate would not lock or alarm in the event of a power outage and should be monitored if a power outage occurred. In addition, staff interviewed acknowledged residents at risk for elopement were to be closely monitored at all times, including when a power outage occurred. -Review of the CQI minutes and interview with the Administrator on 04/04/12, at 11:00 AM, revealed meetings had been held with the Administrative staff (Administrator, Assistant Administrator, Director of Nursing, Minimum Data Set (MDS) Coordinator, and Social Services Director) on 03/15/12, 03/16/12, and 03/28/12 to update care plans for Resident #1 and other residents assessed to be at risk for wander/elopement behaviors. The Administrator also stated the administrative staff/CQI committee reviewed, revised, and created policies; reviewed in-service content and training; and developed forms for staff to document the Unit door and the courtyard gate locks/alarms were monitored and functioning. -Reviews of the Door Alarm Policy (reviewed by the facility on 03/15/12), Missing Persons Policy (revised by the facility on 03/15/12), and Wander/Elopement Prevention Policy (reviewed by the facility on 03/15/12) were conducted with no concerns identified. -Interview with the facility's local power company on 04/04/12 at 10:00 AM confirmed the facility had contacted the company on 03/15/12	F 490		

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F 490	Continued From page 34 regarding the need for the exit door to the Unit and the court yard door to be placed on emergency generator power.	F 490		